



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG - Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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May 29, 2009

RECEIVED

JUN 26 2009

FACILITY STANDARDS

Kathy Prophet
Preferred Community Homes - Bedford
398 Edgar Court
Meridian, ID 83642

Provider #13G039

Dear Ms. Prophet:

On May 26, 2009, a follow-up visit of your facility was conducted to verify corrections of deficiencies noted during the survey of January 26, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

Kathy Prophet
May 29, 2009
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 11, 2009**, and keep a copy for your records.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

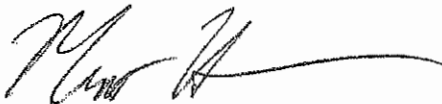
You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by June 11, 2009. If a request for informal dispute resolution is received ~~after June 11, 2009, the request will not be granted. An incomplete informal dispute resolution process~~ will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please feel free to call us at 334-6626.

Sincerely,



MATT HAUSER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/26/2009
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - BEDFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 398 EDGAR COURT MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 000}	INITIAL COMMENTS The following deficiencies were cited during your follow up survey. The surveyors conducting your survey were: Matt Hauser, QMRP, Team Leader Monica Williams, QMRP Common abbreviations used in this report are: HRC - Human Rights Committee IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional RSC - Resident Service Coordinator	{W 000}	"Preparation and Implementation of this plan of correction does not constitute admission or agreement by Bedford with the facts, findings or other statements as alleged by the state agency dated May 26, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Bedford – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227	W 227 483.440 (c)(4) INDIVIDUAL PROGRAM PLAN Individual #1 has had the recommendation of the physical therapist to consult with Norco on his positioning while he is in his wheelchair. Recommendations will be followed and positioning guidelines will be available to the staff. Individual #4 now has objectives in place to teach him the importance and function of his adaptive equipment and we are now recording and addressing his refusals for that equipment.		
	This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the IPP included objectives to meet the needs for 2 of 4 individuals (Individual #1 and #4) whose IPPs were reviewed. This resulted in a lack of program plans designed to address the needs of individuals in areas most likely to impact their life. The findings include: 1. Individual #1's IPP, dated 7/17/08, documented a 48 year old male diagnosed with profound mental retardation, blindness, seizure disorder, and severe spastic quadriplegia. He used a wheelchair for mobility.			RECEIVED JUN 26 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 227	<p>Continued From page 1</p> <p>During an observation on 5/26/09 from 12:00 - 12:55 p.m., Individual #1 was noted to be in his wheelchair. He was leaning to his right side, with his head against the back support of his wheelchair. His right arm was noted to be curled inside the top of his right sweatshirt sleeve.</p> <p>When asked, the RSC who was present during the observation, stated that Individual #1 had no plan related to proper body alignment.</p> <p>Individual #1's IPP contained no objective or plan related to proper body alignment while he was in his wheelchair.</p> <p>When asked, the QMRP stated, during an interview on 5/26/09 at 3:46 p.m., Individual #1 had no objective or plan related to proper body alignment.</p> <p>The facility failed to ensure Individual #1's IPP contained an objective to meet his physical needs.</p> <p>2. Individual #4 was a 56 year old male diagnosed with schizoaffective disorder, major depressive disorder, and mild mental retardation.</p> <p>His Adaptive Equipment plan, dated 10/13/08, stated he was to wear his dentures on a daily basis, wear his glasses when he was reading or "at other appropriate times," and he was to wear his knee pads when he had open wounds to "allow wounds to heal and to prevent further injury."</p> <p>However, during an observation on 5/26/09 from 12:00 to 12:55 p.m., Individual #4 was noted to be seated at the dining room table, coloring. He was</p>	W 227	<p>In addition all clients who are in wheelchairs have been reviewed and those that can now have repositioning guidelines in place, and furthermore all clients reviewed who can and use adaptive equipment now have objectives in place to teach them the importance and function of the equipment and/or refusal programs to address why they don't.</p> <p>Person responsible: AQMRP, QMRP Monitored monthly by: QMRP Completion Date: June 30, 2009</p>	

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W 227	Continued From page 2 not wearing his glasses or his dentures. A large white bandage was noted to cover his left knee. When asked, the RSC, who was present during the observation, stated Individual #4 had fallen and injured his left knee. When asked about Individual #4's dentures, reading glasses, and knee pads, the RSC stated he refused to wear them. When asked, the QMRP stated on 5/26/09 during interview from 4:15 - 5:00 p.m., Individual #4 did not have objectives or plans to teach him the importance and function of his equipment or to address his refusals.	W 227			
W 276	The facility failed to ensure individuals had objectives or plans to meet their identified needs. 483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, record review, and staff interviews it was determined the facility failed to ensure policies and procedures specified all facility approved interventions to manage individuals' inappropriate behavior. This directly impacted 2 of 4 individuals (Individuals #2 and #4) reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in interventions being used to manage inappropriate behavior without the necessary policies and procedures to address the	W 276	W276 483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facilities Behavior Modification Hierarchy and Definitions policy will be adequately developed to include and define one to one staff supervision. All clients who have behavior programs will be reviewed and revised as needed to define these new definitions, and HRC consent will be in place for those programs that include restrictive components as defined by the new Behavior Modification Hierarchy and Definitions policy. Person Responsible: PCH Administrative Team Monitored quarterly by: PCH Administrative Team Completion Date: August 1, 2009		

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W 276	<p>Continued From page 3 interventions. The findings include:</p> <p>1. Individual #2 was a 44 year old male diagnosed with severe mental retardation.</p> <p>Individual #2's behavior program for elopement, dated 9/19/08, stated Individual #2 was "one to one staff while in the community." In the "General Instructions" section, it stated when Individual #2 was in the backyard, staff needed to "maintain line of sight" of Individual #2.</p> <p>Individual #2's record included guardian approval and HRC consent for increased supervision.</p> <p>The facility's Behavior Modification Method Hierarchy and Definitions, dated 5/30/08, stated increased staff supervision and monitoring was not restrictive and did not require guardian approval and HRC consent.</p> <p>When asked, the Administrator stated on 5/26/09 during interview from 4:15 - 5:00 p.m., one on one supervision was considered restrictive and the policy was in process of being revised.</p> <p>2. Individual #4 was a 56 year old male diagnosed with schizoaffective disorder, major depressive disorder, and mild mental retardation.</p> <p>Individual #4's IPP included an addendum, dated 12/28/08, which stated he needed to be line of sight and within arms length to keep him safe and prevent falls, as he was known to purposely fall for attention.</p> <p>Individual #4's record included guardian approval and HRC consent for increased supervision.</p>	W 276		

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W 276	Continued From page 4 However, the facility's Behavior Modification Method Hierarchy and Definitions, dated 5/30/08, stated increased staff supervision and monitoring was not restrictive and did not require guardian approval and HRC consent. When asked, the Administrator stated on 5/26/09 during interview from 4:15 - 5:00 p.m., one on one supervision was considered restrictive and the policy was in process of being revised. The facility failed to ensure the Behavior Modification Method Hierarchy and Definitions policy was adequately developed to include and define one to one staff supervision.	W 276			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. -This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals were provided with and taught to care for their adaptive devices for 2 of 4 individuals (Individuals #3 and #4) whose adaptive equipment was reviewed. This resulted in individuals not utilizing adaptive equipment to increase their level of independence. The findings include: 1. Individual #4 was a 56 year old male diagnosed with schizoaffective disorder, major depressive	W 436	W436 483.470(g)(2) SPACE AND EQUIPMENT Individual #4 now has objectives in place to teach him the importance and function of his adaptive equipment and we are now recording and addressing his refusals for that equipment. Individual #3's wheelchair has been cleaned and the arm rests are in the process of being replaced. A new cleaning list has been revised to ensure wheelchairs are being cleaned daily. Training has been implemented on the home RSC to ensure she is monitoring all clients' adaptive equipment and keeping it in good repair and working order. Person Responsible: AQMRP, and RSC Monitored by: RSC Completion Date: programs completed and in place, wheelchair repair in process completed by August 1, 2009		

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W 436	<p>Continued From page 5</p> <p>disorder, and mild mental retardation.</p> <p>Individual #4's record included a service objective for him to use adaptive equipment which included dentures, knee pads, and reading glasses.</p> <p>His Adaptive Equipment plan, dated 10/13/08, stated he was to wear his dentures on a daily basis, wear his glasses when he was reading or "at other appropriate times," and he was to wear his knee pads when he had open wounds to "allow wounds to heal and to prevent further injury."</p> <p>However, during an observation on 5/26/09 from 12:00 to 12:55 p.m., Individual #4 was noted to be seated at the dining room table, coloring. He was not wearing his glasses or his dentures. A large white bandage was noted to cover his left knee. When asked, the RSC, who was present during the observation, stated Individual #4 had fallen and injured his left knee. When asked about Individual #4's dentures, reading glasses, and knee pads, the RSC stated he refused to wear them.</p> <p>When asked, the QMRP stated on 5/26/09 during interview from 4:15 - 5:00 p.m., Individual #4 did not have objectives or plans to teach him the importance and function of his equipment or to address his refusals.</p> <p>The facility failed to ensure Individual #4 was taught to use his adaptive equipment needed to increase his functioning ability and independence.</p> <p>2. Individual #3's IPP, dated 10/14/08, documented a 46 year old female diagnosed with moderate mental retardation and seizure</p>	W 436			

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W 436	<p>Continued From page 6</p> <p>disorder. She used a wheelchair for mobility.</p> <p>An observation was conducted at the facility on 5/26/09 from 12:00 - 12:55 p.m. During that time, it was noted that Individual #3's wheelchair seat belt and brakes were covered with dried food debris. It was also noted that both arm rests on her wheelchair had approximately 7 inch torn areas, where the vinal had split.</p> <p>When asked, the RSC, who was present during the observation, stated the graveyard staff was responsible for cleaning wheelchairs and had not been completing their duties lately.</p> <p>The facility failed to ensure Individual #3's wheelchair was clean and kept in good repair.</p>	W 436			

Bureau of Facility Standards

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{MM380}	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include:</p> <p>An environmental survey was conducted on 5/26/09, from 12:00 - 12:55 p.m. and the following concerns were noted:</p> <ul style="list-style-type: none"> - The padded footboard of Individual #1's bed had 2 large holes in it, exposing foam. - The comforter on Individual #3's bed had a 9 inch tear in it. - The sink in the back bathroom was slow to drain. - There was what appeared to be food splattered on the kitchen cupboard with the cups and on the door of the Lazy Susan cupboard. - There was baked-on grease on 2 muffin tins. - There was baked-on grease on 5 baking sheets. - There was dried food on the green cutting board 	{MM380}	<p>MM380 16.03.11.120.03(a) Building and Equipment</p> <p>new padded footboard of Individual #1's bed has been ordered. The comforter in Individual #3's bed has been torn away and replaced with a new one.</p> <p>The sink in the back bathroom has been assessed by a Plumber and a deep hair clog was removed. The AQMRP personally cleaned the kitchen cupboard with the cups and on the door of the Lazy Susan cupboard. 2 muffin tins have been replaced as well as all baking sheets. The green cutting board has been cleaned and sanitized. The food debris and dust has been wiped out and cleaned on the inside of the cupboard next to the refrigerator. The cabinet containing flour, sugar, and coffee creamer has been cleaned out and sanitized. The chair in the medication room has been thrown away and replaced with a new one.</p> <p>Person responsible: AQMRP, and RSC Monitored by: RSC Completion Date: June 8, 2009</p> <p style="text-align: center; font-size: 1.5em; font-weight: bold;">RECEIVED</p> <p style="text-align: center; font-size: 1.2em; font-weight: bold;">JUN 26 2009</p> <p style="text-align: center; font-weight: bold;">FACILITY STANDARDS</p>	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

BK9H12

If continuation sheet 1 of 3

TITLE

(X6) DATE

Bureau of Facility Standards

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{MM380}	Continued From page 1 in a cabinet. - There was food debris and dust on the inside of the cupboard next to the refrigerator. - There was white powder on the shelf of the cabinet containing flour, sugar, and coffee creamer. - The chair in the medication room had one 3 inch tear in the seat and no less that 3 smaller tears, exposing foam. Repeat deficiency.	{MM380}			
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	MM429 16.03.11.120.11 Equipment and Supplies for Resident Care Refer to W436		
MM520	16.03.11.200.03(a) Establishing and Implementing policies The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520	MM520 16.03.11.200.03(a) Establishing and Implementing policies Refer to W276		

Bureau of Facility Standards

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MM729	Continued From page 2	MM729			
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	MM729 16.03.11.270.01(d) Treatment Plan Objective Refer to W227		